45th 2/25/17 70th 3/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445456	A. BUILDING 01 • MAIN BUILDING 01 B. WING	01/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SWEETWATER NURSING CENTER	976 HWY 11 SOUTH SWEETWATER, TN 37874

(X4) ID PREFIX TAG	SUMMARY STATEMENT of DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A life safety survey was conducted by the state of Tennessee Department of Health, Division of health licensure and regulation office of health care facilities on 1/9/17. During this life safety survey, Sweetwater Nursing Center was not found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life safety from fire, and tile related National Fire Protection Association (NFPA) standard 101 - 2012 edition.	K000		
K 271	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38•. 18.2.7, 19.2.7, S&C 05-38 This STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to maintain exit discharges. This deficiency affected 2 of 8 smoke compartments. The findings include: Observation and interview with the maintenance director on 1/9/17 between 8:18 AM and 8:30 AM revealed the exit discharges at the South wing nurses station and by room 214 had snow and ice accumulations. The maintenance director was present when the	K 271	<u>Corrective Action for Targeted Area</u> On 1/9/17 the Maintenance Director had the snow and ice removed at the exit discharges located by the South wing nurses station and room 214. <u>Identification of Area with Potential to be affected</u> On 1/9/17 the Maintenance Director checked facility exit discharge areas for accumulations of snow and ice and found no other areas affected <u>Systematic Changes</u> Measures to assure/meet compliance includes daily monitoring of facility exit discharges for snow and ice when the outside temperature drops to 32 degrees Fahrenheit or below and maintain a supply of melting salt to use in preventing any such build up as the weather requires.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bettie E. Mosley	ED/CEO	1/26/17

Any deficiency $statement ending with an asterisk (*) denotes deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 271	Continued deficiencies were identified and was acknowledged by the administrator during the exit conference on 1/9/17.	K271	<u>Monitoring</u> Results of these audits will be presented monthly by the Maintenance Director to the Quality Assurance Performance Improvement Committee for review and recommendations until the desired threshold of 100% compliance is met for 3 consecutive months. The Executive Director and Maintenance Director will follow up on recommendations from the QAPI Committee to assure compliance. The Quality Assurance Performance Improvement (QAPI) Committee consists of the Executive Director/Administrator, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator.	QAPI 1/26/17

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K 711 SS=D	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure dietary staff was trained on the hood suppression system and components. This deficiency affected 1 of 8 smoke compartments. The finding includes: Observation and interview on 1/9/17 at 10:23 AM revealed 2 of 2 dietary staff were unfamiliar with the hood suppression system and components. NFPA 101, 9.2.3, NFPA96, 10.5.7 The maintenance director was present when the deficiency was identified and was acknowledged by the administrator during the exit conference on 1/9/17.	K 711	<u>Corrective Action for Targeted Area</u> On 1/9/17 and 1/10/17 the Maintenance Director and Dietary Manger in-serviced kitchen staff to familiarize them with the components and operation of the kitchen hood suppression system. On 1/20/17 the Maintenance Director met with kitchen staff on the operation and components of the hood suppression system and found staff competent. <u>Identification of Area with Potential to be affected</u> The hood suppression system is located in the kitchen and no other area in the facility is affected. Any dietary staff member has the potential to be affected by this practice. <u>Systematic Changes</u> Measures to assure/meet compliance includes a monthly audit conducted by the Maintenance Director of kitchen staff's knowledge of the kitchen hood suppression system and compliance with NFPA 101 and NFPA 96. Also new kitchen staff will be in-serviced on hire for correct operation of the kitchen hood suppression system.	

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K 711	Continued	K 711	**Monitoring** Results of these audits will be presented monthly by the Maintenance Director to the Quality Assurance Performance Improvement Committee for review and recommendations until the desired threshold of 100% compliance is met for 3 consecutive months. The Executive Director and Maintenance Director will follow up on recommendations from the QAPI Committee to assure compliance. The Quality Assurance Performance Improvement (QAPI) Committee consists of the Executive Director/Administrator, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator.	1/20/17